

# 2014 Annual Report Due: July 01, 2015

	✓ # R	equired Filing Ch	ecklist		
	1 20	014 Annual Report	Checklist		
	2 B	ackground Informa	tion		
	3 L	ist of Insurers/Self-	Funded Plans		
	4 20	014 Audited Financ	rial Statement		
	5 O	Officer's Verification	n Form		
Company Name:					
DBA Name:					
License #	FEIN:				
		·			
Business Address:					
Mailing Addragg					
Mailing Address:					
Business Phone:	Business E-mail:				
Business Website:					
Contact Person:			Title:		
Contact Phone:	Contact E-mail:				
Submission:					
e-mail: doi.tpa@doi.idaho.gov Subject: 2014 Annual Report - [company name]		Mail: name]	Idaho Department of Insurance Examinations Section PO BOX 83720 Boise, ID 83720-0043		



## Background Information

Please read and answer the following questions:

YES NO		
	1.	Has there been any administrative action taken against the administrator in another jurisdiction or by another governmental agency within the last year?  If yes, please provide the following:  a. a copy of the order,  b. consent order or  c. other relevant legal documents
	2.	Has any owner, partner, officer or director been involved in an administrative proceeding regarding any professional or occupational license within the last year?  If yes, please provide the following:  a. a written statement identifying the type of license and explaining the circumstances of each incident,  b. a copy of the Notice of Hearing or other document that states the charges and allegations, and  c. a copy of the official document which demonstrates the resolution of the charges or any final judgment.
	3.	Has there been a change of officers within the last year?  If yes, please provide the following:  a. a list of the new officers and their position
	4.	Does the administrator administer or will administer self-funded health plans subject to regulation under chapter 40 or 41, title 41, Idaho Code?



#### List of Insurer and Self-Funded Plans

On a separate attachment, please include the following information

List of insurer and self-funded plans the administrator had agreements during the preceding fiscal year.

#### Include:

Insurance Company Name
NAIC #
Address
City, State, Zip Code
Contact Telephone Number
Number of Idaho residents covered by plan

Employer and Trust Name Address City, State, Zip Code Contact Telephone Number Number of Idaho residents covered by plan



### Officers' Verification

The report must be verified by at least two (2) officers of the administrator.

Annual Report for the fiscal year ending:					
The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement is in full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above and of its income and deductions therefrom for the period ended and have been completed in accordance with the Generally Accepted Accounting Principles according to the best of their information, knowledge and belief, respectively.					
The undersigned owner, partner, officer or director of the applicant hereby certifies, under penalty of perjury, that all of the information submitted in this reporting and attachments is true and complete and I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license or registration revocation and may subject me and the applicant to civil or criminal penalties.					
Signature	Date				
Printed Name	Title				
Signature	Date				
Printed Name	Title				